STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155710	A. BUILDING 00 B. WING	02/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHASE CENTER	2 CHASE PARK LOGANSPORT, IN 46947

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: January 26,27,28,29,30 and February 2, 2015 Facility Number: 000021 Provider Number: 155710 AIM Number: 100275270 Survey Team: Rita Mullen, RN-TC Bobette Messman, RN Maria Pantaleo, RN Census Bed Type: SNF: 1 SNF/NF: 72 Total: 73 Census Payor Type: Medicare: 5 Medicaid: 56 Other: 12 Total: 73 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed by Tammy Alley RN on February 9, 2015.	F000000	Please accept the attached plan of correction as credible allegation of compliance to the deficiencies cited during our Annual Health Inspection. I would like to formally request your consideration for granting this facility paper compliance. Chase Center submits this Plan of Correction (POC) in accordance with specific regulatory requirements. The submission of the POC does not indicate an admission by Chase Center that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Chase Center. If after reviewing our plan of correction you have any questions or require additional information, please do not hesitate to contact Lacey Schnurpel, Administrator at 574-753-4137.Thank you	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to accurately and completely monitor and track depressive behaviors for 1 of 5 residents reviewed for unnecessary Medications (Resident #83). Findings include: The clinical record of Resident #83 was reviewed on 1/29/15 at 1:29 p.m. Diagnoses included, but were not limited to, dementia, delusional, Alzheimer's	F000329	F3291. Resident #83 is currently receiving Cymbalta 60mg. for depression and Diabetic Peripheral Neuroleptic Pain and Anxiety. Resident #83 is also receiving Remeron 15mg. for Depression. Resident #83 is currently receiving a Gradual Dose reduction (GDR) of Seroquel from 150mg. to 100mg., effective 2/6/15. Resident #83 will receive another gradual dose reduction on 4/7/15 to 50mg., as long as the resident does not display any behavior concerns and adjusts well to the GDR. At	02/23/2015

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	disease and psychosis. A physician's order for Celexa (an antidepressant) 50 mg (milligrams) was discontinued and changed to Cymbalta 60 mg on 6/26/14 "...due to symptoms not fully resolved." A review of the Medication Administration Record (MAR) for the months of May and June 2014 indicated the behavior of depression was to be monitored. A Targeted Charting Review, dated 2/2/15, indicated , "...Resident has had approximately 6-8 behaviors since April, 2014. At present time resident is doing well...." A review of the Nursing notes from April 30, 2014 to present, indicated five Targeted Chartings on 6/29/14, 7/12/14, 9/2/14, 10/08/14 and 10/29/14 not 6 - 8 behaviors. During an interview with the Director of Nursing (DON), on 2/2/15 at 11:15 a.m., she indicated she was aware he was having behaviors but not when, how many times with staff and other residents. She indicated she did not know which interventions were effective. A policy entitled "Behavior		the present time, this resident is doing well with the current GDR in place.2. Resident #83's careplan for Depression and Anxiety was updated on 2/19/15. The PHQ9 (Depression Screen) was completed on 2/20/2015, for this resident. Results will be shared with Crystal Ridenhour, Nurse Practitioner from Four County Counseling Center at the Resident's appointment on Monday, 2/23/15. Pharmacy recommendation received and reviewed with the Behavior Committee on 2/18/15 to reduce resident's Remeron to 7.5mg for 15 days and then discontinue. Nurse Practitioner notifed of recommendation on 2/18/15 and requested to wait until visit with resident on 2/23/15. 3. The Electronic Charting system used at Chase Center was improved on 2/18/15 to accurately assess signs and symptoms of Depression. The system would allow the nurse to put a "Y" for yes, "N" for no on the MAR/TAR to identify if the resident was displaying signs and symptoms of depression. The system upgrade will now allow the nurse to put their initials on the MAR/TAR and they will be directed to the "Behavior/Depression" folder. This will allow the nurse to accurately document when a resident displays a behavior and/or signs/symptoms of depression. Education was initiated on 2/20/15 and will be	

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	Changes/Modification," dated 2-2013, received from the DON on 2/2/15 at 10:30 a.m., indicated the following: "...Procedure:...4. Document the resident's behavior changes clearly and objectively in the medication record. Include any observation, intervention and outcome...." 3.1-48(a)(4)		completed on 2/23/15 with all nurses. The "Behavior Changes/Modification" policy was revised on 2/20/15 and education was initiated on 2/20/15 and will be completed on 2/23/15. (See Exhibit 1-6)4. All residents receiving anti-depressants will be reviewed monthly at the behavior meeting, held with Resident Care Managers, Director of Nursing, Social Services Director, Activity Director, Administrator and the consultant pharmacist to ensure unnecessary medications are not being used. The Director of Nursing will monitor and report on this matter at the monthly Quality Assurance Performance Improvement (QAPI) meeting for 18 months and the QAPI committee will review effectiveness of current procedure for continuation. This deficiency will be corrected on 2/23/15	
F000371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to ensure that food was properly labeled, and dated in the dry storage area and the "Cook's" refrigerator in one of one kitchens in the	F000371	F3711. No resident was affected by this alleged deficit practice.2. No residents were affected by this alleged deficit practice. All residents had the potential to be affected by this alleged deficit	02/20/2015

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	facility. This deficiency had the potential to affect 73 of 73 residents who received meals in the facility. Findings include: During the tour of the kitchen on 1/26/2015 at 9:35 a.m., with the Dietician and Dietary Manager, the following observations were made: 1.The dry storage area was observed to have a 2 bags of potato chips not sealed, 2 bags of bread opened and no dates on the bags, and 2 bags of buns opened and no dates on the bags. 2.The "Cook's " refrigerator was observed to have 1 plastic zip lock bag of 10 chicken breasts with no date on the bag. During an interview on 1/28/2015 at 2:00 p.m., the Dietary Manager indicated all open food items should have been sealed, dated and stored. The facility policy for " Food and Supply Storage Procedures, " undated, received from the Dietary Manager on 1/28/2015 at 2:10 p.m., indicated "... Date and rotate items...." . 3.1-21(i)(2)(3) .		practice.3. The "Food and Supply Storage procedures" policy was revised on 2/16/15 and education began on 2/16/15 and was completed on 2/18/15 with all dietary personnel. (See Exhibit A1 & A2)4. The "Quality Control Indicators Daily Inspection" policy was developed on 2/16/15 and education began on 2/16/15 and was completed on 2/18/15 with all dietary personnel. (See Exhibit B1 & B2)The audit will be completed daily by the Dietary Manager. In the absence of the Dietary Manager the charge cook is responsible for the completion of this audit, to ensure proper dates and storage of all food items. (See Exhibit C)The "Food and Nutrition Services Sanitation Audit" will be completed monthly by the Dietitian. The findings in this audit will be reported at the monthly Quality Assurance Performance Improvement (QAPI) meeting. The Dietary Manager will report on this monthly for 18 months. The QAPI committee will evaluate after 18 months, before discontinuing. (See Exhibit D)	

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